HMO SERVICES IN OTHER LANGUAGES:

A Portrait of California Health Plans and Linguistic Services for Limited English Proficient Members

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BUSINESS, TRANSPORTATION AND HOUSING AGENCY

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EXECUTIVE SUMMARY

California is a very diverse state, and the population enrolled in its health maintenance organizations (HMOs) reflects this diversity. HMOs are faced not only with the challenge of providing appropriate health care services to members, but also providing services to enable access to care for limited English proficient (LEP) members. This report presents findings from the Office of the Patient Advocate (OPA) *Cultural and Linguistic Services Information for Health Plans Survey 2002*; discusses the implications for California consumers; and provides programmatic and policy recommendations.

SURVEY

In 2002, OPA developed a survey with input from the OPA Cultural & Linguistic Services Work Group. The survey was sent to 20 full-service health plans in California, including nine of the largest commercial health plans as well as 11 Medi-Cal local initiatives and their plan partners. The survey contained five main topic areas including the availability of telephone interpreter services, face-to-face interpreters, bilingual providers, translated written materials, and the monitoring of grievances related to language and cultural barriers. The information collected was voluntarily self-reported. A 100% response rate was obtained. Although there were a total of 47 full-service health plans in the State, the 20 plans that participated in the survey accounted for over 90% of all HMO enrollees across four lines of business: commercial, Medi-Cal, Healthy Families, and Medicare.[1]

KEY FINDINGS

All plans reported that they have telephone interpreters available for LEP members at no cost and have bilingual staff members who speak a language other than English. Across all lines of business, 85% of plans reported that they contract for language line services. Eighty percent of plans reported that they offer telephone interpreters at medical points of contact. Similarly, 80% offer access to face-to-face interpreters for some, but not necessarily all, LEP members at medical points of contact. Ninety percent of those plans that offer face-to-face interpreter services reported that they do so at no cost to the member.

All plans reported that they translate member materials into non-English languages. Across all lines of business, 90% of plans reported that translated member materials are available to LEP members upon enrollment for at least one line of business. Ninety-five percent of plans reported that they have a provider directory that specifies non-English languages of their doctors, and 85% reported that they offer the provider directory in the plan's threshold languages for at least one line of business.[2]

Although many health plans provide linguistic services for their members, there is variability in how members are informed about available services as well as how they are informed about how to access services. Many HMOs provide certain interpreter and translation services for their Medi-Cal, Medicare, and Healthy Families members to meet federal and state contract require-

[1] California Statewide Enrollment by Health Plan for the Month of March 2002. Cattaneo & Stroud, Inc.

[2] Threshold languages are the primary non-English languages spoken by population groups meeting a numeric threshold as defined by State and Federal regulators for use in translating written materials.

ments, but do not routinely offer the same services to their commercial members, who are not covered by these requirements.

Recommendations

In order to improve the provision of linguistic access services, health plans should:

1. provide the same linguistic services to all members regardless of type of coverage or line of business;
2. assess member language needs and tailor linguistic services to those needs;
3. adopt standardized procedures for how members obtain interpreter services;
4. develop standardized processes for informing members about how to obtain translated written materials.
5. uniformly evaluate the language proficiency of providers and bilingual staff.

Conclusions

California's delegated model and the different types of coverage of members contribute to the complexity of the state's managed health care system. This is particularly evident in the provision of linguistic services for LEP members. Survey findings illustrate that some linguistic services are the responsibility of the health plan while others may be shared or delegated to a contractor.[3] Additionally, the linguistic services offered may vary based on the member's type of coverage. The report recommendations to standardize processes for providing linguistic services to members, regardless of type of coverage, begin to address the potential confusion that may unnecessarily limit access to entitled benefits.

[3] A contractor may include a delegated medical group, independent practice association (IPA), individual provider or in the case of the local initiatives, a health plan partner.

1. INTRODUCTION

California is a very diverse state, and the population enrolled in health maintenance organizations (HMOs) reflects this diversity. In fact, 41% percent of the state's approximately 18 million HMO members are non-white. Latinos account for 19% of total HMO enrollment, followed by Asians (12%), African Americans (7%), and Native American and other (3%). More than one-third of California's HMO population communicates in a language in addition to or other than English at home and 4% do not speak English very well or at all.[4]

HMOs are faced not only with the challenge of providing appropriate health care services to members, but also providing services to facilitate access to care for limited English proficient (LEP) members. Appropriate delivery of health care services depends greatly on effective communication between the member and their health care provider or health plan representative. This communication may occur at many different points of contact between the member and the HMO, e.g., when the member calls the plan; when the member visits the treating physician; or when the member receives written materials from the health plan.

The ability of health plans to deliver services to their LEP members is explored in this report through findings from the OPA *Cultural and Linguistic Services Information for Health Plans Survey 2002*. A discussion of the implications of these findings for California consumers, as well as programmatic and policy recommendations are also presented.

2. BACKGROUND AND HISTORY

The Office of the Patient Advocate (OPA) is an independent office under the Business, Transportation and Housing Agency charged with providing information and advice to California HMO enrollees regarding how best to access services from their health plan. The managed care system is inherently complex, and this is certainly the case for the provision of linguistic services. For this reason, OPA has examined the linguistic services that health plans provide to limited English proficient (LEP) members.

YEAR 1 (FY 2000-01)

In the Fall of 2000, OPA began meeting informally with a group of consumer advocates with a focus on cultural and linguistic issues. This informal group, consisting of various state advocacy groups, developed a list of questions to be included in a letter sent out to all Knox-Keene licensed health plans in February 2001. The intent of the letter was to obtain baseline information about the status of cultural and linguistic services that health plans offer their members.

OPA received a total of 67 (out of 109) responses to this request for information. Because the questions in the letter were open-ended, responses varied in detail and length, ranging from one page to a three-inch notebook, including brochures.

At the same time, OPA was moving to develop its first statutorily-mandated, annual report card on HMO quality using HEDIS clinical data and CAHPS patient satisfaction data. In June 2001, a consensus was reached (in response to recommendations from consumer advocates) that OPA would also move forward to include cultural and linguistic information on the 2001 California

[4] GF Kominski, PL Davidson, CL Keeler, N Razack, LM Becerra, R Sen, *Profile of California's HMO Enrollees: Findings from the 2001 California Health Interview Survey*. UCLA Center for Health Policy Research, 2003.

HMO Report Card. Health plans were recontacted and asked to confirm responses to a shortened series of questions specific to five indicator areas that would be used on the Report Card:

- Telephone Interpretation Services
- Access to Face-to-Face Interpreters
- Bilingual Provider Directory
- Non-English Print Materials
- Language Barrier Complaint Monitoring

The Year 1 Report Card, released in September 2001, included plan responses in these areas in a Yes/No format. Information provided was intended to let the Report Card users know if a service was available from the health plan. Some health plans chose to respond "Not Reported" when they were unable to answer with a simple "yes/no" response.

YEAR 2 (FY 2001-02)

At the end of calendar year 2001, OPA decided to formalize the activities of consumer advocates and health plans in preparation for the Year 2 Report Card. In January 2002, the Cultural & Linguistic Services Work Group was created via a nomination and recruitment process. The Work Group represented various stakeholder groups (including consumer advocates, health plans, government agencies, and academic researchers) and provided expertise and advice to OPA regarding the cultural and linguistic services provided by California's health plans to individuals with limited English-speaking ability. It provided assistance and advice on how to describe and evaluate the extent and quality of these services and to assure health care access for this population.

One primary goal of the Year 2 Report Card was to incorporate a number of incremental improvements from Year 1 based on focus group findings, as well as recommendations from stakeholders. The survey for Year 2 would contain the same indicators as the Year 1 Report Card.

3. SURVEY

In January 2002, OPA reviewed the indicators from Year 1 to develop the Year 2 Cultural and Linguistic survey. Also at that time, the Cultural & Linguistics Services Work Group convened to provide input on survey design. The Work Group requested that the data collected be reported to consumers by line of business. The survey questions were then developed with this goal in mind. Data collected included information on the following:

- **Telephone Interpretation Services:**
  This section collected information on access to telephone interpreters for limited English proficient (LEP) members; whether telephone interpreter services are provided free of charge; how members are informed about accessing the services; how members receive telephone interpretation services at medical points of contact; and whether the member is discouraged from using family or friends to serve as interpreters. Additional information was collected about whom an LEP enrollee speaks to when calling the plan and how the proficiency of language skill is assured if bilingual health plan staff speak directly to the member.
- **Access to Face-to-Face Interpreters:**
  This section collected information on access to face-to-face interpreters for both limited English proficient (LEP) members as well as hearing-impaired members;

whether face-to-face interpreter services are provided free of charge; how members are informed about accessing the services; how members receive face-to-face interpretation at medical points of contact; and whether the member is discouraged from using family or friends to serve as interpreters. Additional information was collected on how the proficiency of language skill is assured if bilingual health plan staff provide interpretation services.

- **List of Bilingual Providers:**
  This section collected information on whether the plan offers a provider directory that specifies non-English languages spoken by the provider; if the provider directory is offered in the plan's threshold languages; how members are informed about obtaining a provider directory in their language; whether the plan assesses provider language proficiency; and if the plan has procedures in place to monitor its non-English speaking member population and to adjust or target provider contracting accordingly.

- **Written Materials in Languages Other than English:**
  This section collected information on whether member-informing documents (member handbook or evidence of coverage, member newsletter, member satisfaction surveys, grievance/complaint process materials, welcome letter, preventive health care reminders, other) are available in the plan's threshold languages; how members are informed that these materials are available; and where to access them.

- **Monitoring of Grievances Related to Language and Cultural Barriers:**
  This section collected information on whether the plan monitors grievances/complaints specific to language barrier problems; how language barrier grievances/complaints are tracked; whether the plan monitors grievances/complaints specific to cultural barriers; how cultural barrier grievances/complaints are tracked; and how members are informed in threshold languages about how to file a grievance/complaint.

The initial draft of the survey was developed, and there was a public comment period. The survey was revised and again went through extensive comment and revisions in April 2002. The survey instrument was then pilot tested with two health plans prior to general release. The survey was finalized in May 2002. Appendix I provides a copy of the *Cultural and Linguistic Services Information for Health Plans Survey 2002*.

Survey Implementation

The survey was distributed to 21 health plans in May 2002. Ten were the commercial health plans on the Year 1 Report Card that participated in the California Cooperative Healthcare Reporting Initiative (CCHRI). Additionally, per the recommendation of the Work Group, Medi-Cal local initiatives were invited to participate. Local initiatives are the non-profit public entity health plans that are contracted to provide services to Medi-Cal and Healthy Families enrollees.[5] A letter requesting participation in the Cultural and Linguistic survey was sent to health plan CEOs and a copy was emailed to key contacts in the health plan in May of 2002. Responses were provided voluntarily by the health plans.

PARTICIPATING HEALTH PLANS / OPA CULTUTAL & LINGUISTIC SERVICES INFORMATION FOR HEALTH PLANS SURVEY 2002 (Including Lines of Business)

Exhibit 1

PLAN	Commercial	Medi-Cal	Healthy Families	Medicare
1. Aetna US Healthcare of California	x			x
2. Blue Cross of California	x	x	x	x
3. Blue Shield of California	x		x	x
4. CIGNA Healthcare of California	x			
5. Health Net of California	x	x	x	x
6. Kaiser Permanente	x	x	x	x
7. PacifiCare of California	x			x
8. Universal Care	x	x	x	x
9. Western Health Advantage	x	x		x
MEDI-CAL HEALTH PLANS				
10. Alameda Health Alliance	x	x	x	
11. Care 1st Health Plan		x	x	
12. Community Health Plan	x	x	x	
13. Contra Costa Health Plan	x	x	x	x
14. Health Plan of San Joaquin		x	x	
15. Inland Empire Health Plan		x	x	
16. Kern Family Health Care		x	x	
17. L.A. Care Health Plan		x	x	
18. Molina Healthcare		x	x	
19. San Francisco Health Plan		x	x	
20. Santa Clara Health Plan		x	x	

A survey response rate of 100% was obtained. Subsequently, one health plan went out of business during the study and was therefore excluded from the final analysis and reporting. The remaining twenty participating plans are listed in Exhibit 1. Of the twenty health plans, 12 have commercial lines of business, 16 have Medi-Cal and Healthy Families lines of business, and nine have Medicare lines of business.[6] Across all lines of business, the participating health plans accounted for over 90% of HMO enrollees in the state.[7] Exhibit 2 presents a breakdown of participating health plan enrollment statistics by line of business.

[5] Local Health Plans of California Website. 2002, http://www.lhpc.org/Site%20Directory/site%20Directory.htm.

Exhibit 2 PERCENTAGE OF STATEWIDE PLAN ENROLLMENT INCLUDED IN THE CULTURAL & LINGUISTIC SERVICES SURVEY (By Line of Business)

Line of Business	Statewide Enrollment of All Plans	Plan Enrollment of Survey Participants	Percent
Commercial	12,951,017	12,499,334	97%
Medi-Cal	3,066,058	2,384,001	78%
Healthy Families	521,049	459,081	88%
Medicare	1,432,259	1,332,159	93%
Statewide Total	17,970,383	16,674,575	93%

Source: California Statewide Enrollment by Health Plan and Lines of Business for the Month of March 2002. Cattaneo & Stroud, Inc.

Survey Data Analysis

Survey data were analyzed using the Statistical Package for the Social Sciences (SPSS). As the data collected were descriptive in nature, they were considered informational as opposed to evaluative. The responses provided information regarding language availability, how to access services, and collected the information by type of coverage (line of business). The data were subject to a verification process where health plans received a copy of their own data for review. Plans were then able to revise information where appropriate.

Data Limitations

In collecting information from plans by line of business, results were complicated for a number of reasons.

- The data illustrated that plans sometimes had multiple responses to certain questions. This appeared to be because not all responses were mutually exclusive, e.g. where only the plan is responsible for a particular service. In many cases, the plans reported that both the plan and the plan contractor provide linguistic services.
- Many survey questions ended with the phrase, "Check all that Apply." The data tables in Appendix II record all responses given by a plan for each question.
- Many health plans had written comments for questions either responding to the phrase, "Other, specify" or additional comments to provide further information or explanation where they felt it was appropriate. All "Other, specify"comments and "additional comments" are also recorded in Appendix II in the endnotes for each section.

[6] A health plan may offer more than one line of business which can include commercial, Medi-Cal, Healthy Families, and/or Medicare.
[7] California Statewide Enrollment by Health Plan for the Month of March 2002. Cattaneo & Stroud, Inc.

4. OVERALL FINDINGS

In general, the data indicate that many health plans are working to ensure appropriate linguistic services for their members. All health plans offer interpreter services and translated written materials. Most health plans offer a provider directory that lists the non-English languages spoken by contracted providers. Many plans also translate this directory into non-English languages for LEP members.

There appears, however, to be an inherent complexity in the provision of linguistic services for LEP members. First, there is the delegated model, where delivery of services is often the responsibility of the medical group, IPA or contracted provider, or in the case of the some local initiatives, a health plan partner. Additionally, the data indicate that there may be a distinction in provision of services based on the member's type of coverage. This means that not only may members not necessarily know how and where to obtain services, but that they may be informed differently by the health plan depending on their insurance type.

5. MEMBER LANGUAGE INFORMATION

Member's Preferred Language

Eighteen out of 20 (90%) of plans report that they capture a member's preferred language upon enrollment in the plan for at least one line of business. However, all across lines of business, only ten percent report that they are exclusively responsible to ensure that the member's primary language is documented in their medical records. Twenty percent report both the plan and their delegated medical group, independent practice association (IPA) or individual provider may be responsible. Seventy percent of plans report that they shift this responsibility to their delegated contractor.

NUMBER OF PLANS THAT CAPTURE MEMBER'S PREFERRED LANGUAGE AT ENROLLMENT **TABLE 1**
(By Line of Business)

Line of Business (LOB)	Number of Plans Reporting LOB	Number of Plans Capturing Languages	Percent
Commercial	12	6	50%
Medi-Cal	16	16	100%
Healthy Families	16	16	100%
Medicare	9	6	67%

TABLE 2 WHO IS RESPONSIBLE TO ENSURE A MEMBER'S LANGUAGE IS IN THE MEDICAL RECORD?
(Number of Plans By Line of Business)

	Commercial (n=12)	Medi-Cal (n=16)	Healthy Families (n=16)	Medicare (n=9)
Plan	1	6	6	2
Contractor*	10	10	9	7
Not Reported	1	0	1	0

* A contractor may include a delegated medical group, an independent practice association, an individual provider, or in the case of a local initiative, a health plan partner.

Predominant Non-English Languages

Plans were asked to report on the "predominant" language of non-English speaking members. For the survey, the term *predominant* was defined as at least *three percent of the member base of the health plan*. All health plans with Medi-Cal and Healthy Families lines of business reported Spanish as a predominant non-English language of those members. Approximately 83% of plans with a commercial line of business and 90% with a Medicare line of business reported Spanish as a predominant non-English language of those members. Approximately 40% of plans with Medi-Cal and Healthy Families lines of business; 25% of plans with a commercial line of business; and 33% of plans with a Medicare line of business reported Chinese as a predominant language.

TABLE 3 NUMBER OF PLANS REPORTING A PREDOMINANT NON-ENGLISH LANGUAGE
(By Line of Business)

	Commercial (n=12)	Medi-Cal (n=16)	Healthy Families (n=16)	Medicare (n=9)
Spanish	10	16	16	8
Chinese	3	6	6	3

Monitoring Non-English Speaking Membership

Across all lines of business, 17 out of 20 (85%) of plans reported that they have a procedure in place to monitor their non-English speaking member population and to adjust or target provider contracting accordingly.

NUMBER OF PLANS THAT MONITOR LANGUAGES OF NON-ENGLISH SPEAKING MEMBERSHIP **TABLE 4**
(By Line of Business)

Line of Business (LOB)	Number of Plans Reporting LOB	Number of Plans Monitoring Languages	Percent
Commercial	12	9	75%
Medi-Cal	16	13	81%
Healthy Families	16	13	81%
Medicare	9	6	67%

6. LANGUAGE PROFICIENCY EVALUATION

INDIVIDUAL PROVIDERS

Across all lines of business, four out of 20 (20%) of health plans reported that they evaluate provider language proficiency using a standardized measure. Approximately 60% reported that they assess provider language proficiency via self-report by the provider. Fifteen percent of plans reported no evaluation process. Five percent reported another method of evaluation was used.

HEALTH PLAN STAFF

Bilingual Staff as Telephone Interpreters

Across all lines of business, 85% of health plans reported that they evaluate bilingual staff language proficiency. Ten percent reported that they assess bilingual staff language proficiency via self-report by the staff person. Five percent of plans reported no evaluation process.

Bilingual Staff as Face-to-Face Interpreters

Across all lines of business, 55% of health plans reported they evaluate bilingual staff language proficiency. Ten percent reported that they assess bilingual staff language proficiency via self-report by the staff person. Five percent of plans reported no evaluation process. Twenty percent of plans reported bilingual staff are not typically used as face-to-face interpreters. Ten percent of plans reported a "not applicable" response.

Staff as Sign Language Interpreters

Across all lines of business, five percent of health plans reported they evaluate sign language proficiency of their staff. Five percent of plans reported no evaluation process. Ninety-five percent of plans reported that staff are not used as sign language interpreters.

7. TELEPHONE INTERPRETERS

INDIVIDUAL PROVIDERS

Across all lines of business, all health plans reported that they have telephone interpreter services available for members upon calling the plan. All health plans also reported that they have staff

that speak a language other than English. Additionally, a majority of plans contracted for language line services provided by a company of telephone interpreters that speak with members when an appropriate bilingual staff member is not available. A breakdown of languages spoken by health plan staff is included in Appendix II, Section II. Eighty percent of plans reported that they have telephone interpreters available at medical points of contact, i.e., for physician and non-physician provider office visits, including physical therapists, nurse practitioners, and radiology/ laboratory technicians. Across all lines of business, all plans reported that telephone interpreter services are available at no cost.

TABLE 5 TELEPHONE INTERPRETER SERVICES AT MEDICAL POINTS OF CONTACT (MPoCs)
(Number of Plans By Line of Business)

Line of Business (LOB)	Number of Plans Reporting LOB	Number of Plans Providing Telephone Interpretation @ MPoCs	Percent
Commercial	12	8	67%
Medi-Cal	16	14	88%
Healthy Families	16	14	88%
Medicare	9	7	78%

Who Arranges and Pays for Telephone Interpreter Services

Across all lines of business, 13 out of 20 (65%) of plans reported that they arrange and pay for telephone interpreter services for at least one line of business. However, six out of 20 (30%) of plans reported that their delegated medical group, IPA, or individual provider exclusively arranges and pays for telephone interpreter services for some, but not necessarily all, LEP members. Five percent of plans reported that their commercial members are responsible to arrange for their own telephone interpreter services.

TABLE 6 WHO ARRANGES AND PAYS FOR TELEPHONE INTERPRETER SERVICES?
(Number of Plans By Line of Business)

	Commercial (n=12)	Medi-Cal (n=16)	Healthy Families (n=16)	Medicare (n=9)
Plan	4	11	12	4
Contractor*	3	5	4	2
Member	3	0	0	1
Not Reported	2	0	0	2

* A contractor may include a delegated medical group, an independent practice association, an individual provider, or in the case of a local initiative, a health plan partner.

Discouraging Members from Using Friends and Family as Telephone Interpreters

This issue is important as many LEP members may not be aware that they have the right to a telephone interpreter. LEP members may be tempted to bring a friend or family member with them to a medical appointment to act as an interpreter. However, often that individual is not able to translate medical information correctly or there is private information involved.

Very few plans reported that the member is responsible to arrange for their own telephone interpreter. However, for those plans that reported the member is responsible to arrange for their own telephone interpreter (see Table 6), one of three commercial plans reported that the member is expressly discouraged from using friends or family members to serve as interpreters.

How Members Are Informed about Accessing Telephone Interpreter Services

Members are informed about accessing telephone interpreter services in different ways. Across all lines of business, 45% of health plans reported the use of posters to inform members of telephone interpreter services. Seventy percent of plans reported using member newsletters to inform members. Ninety-five percent of health plans reported that the member handbook/evidence of coverage contains information for members to obtain telephone interpreter services. Forty percent of health plans reported reference to telephone interpreters on the plan website. Additionally, 60% of plans reported other methods to inform members about interpreter services.

HOW PLANS INFORM MEMBERS ABOUT TELEPHONE INTERPRETER SERVICES **TABLE 7**
(Number of Plans By Line of Business)

	Commercial (n=12)	Medi-Cal (n=16)	Healthy Families (n=16)	Medicare (n=9)
Posters	5	9	8	4
Member Newsletter	5	13	13	2
Evidence of Coverage	7	16	15	7
Website	3	5	6	2
Other	5	10	11	3

Note: Health plans utilize multiple strategies to communicate with members. In this table, each cell represents the number of plans reporting a particular strategy for that line of business.

8. FACE-TO-FACE INTERPRETERS

Across all lines of business, 80% of health plans surveyed reported that they have access to face-to-face interpreters available for at least one line of business at medical points of contact. Also, 80% of all plans report that face-to-face interpreter services are available at no cost for some, but not necessarily all, LEP members.

TABLE 8 FACE-TO-FACE INTERPRETER SERVICES AT MEDICAL POINTS OF CONTACT (MPoCs)
(Number of Plans By Line of Business)

Line of Business (LOB)	Number of Plans Reporting LOB	Number of Plans Providing Face-to-Face Interpretation @ MPoCs	Percent
Commercial	12	8	67%
Medi-Cal	16	13	81%
Healthy Families	16	13	81%
Medicare	9	7	78%

TABLE 9 FACE-TO-FACE INTERPRETER SERVICES AT NO COST TO MEMBER
(Number of Plans By Line of Business)

Line of Business (LOB)	Number of Plans Reporting LOB	Number of Plans Providing Face-to-Face Interpretation @ MPoCs	Percent
Commercial	12	8	67%
Medi-Cal	16	15	94%
Healthy Families	16	15	94%
Medicare	9	7	78%

Who Arranges and Pays for Face-to-Face Interpreter Services

Across all lines of business, 13 out of 20 (65%) of plans reported that they arrange and pay for face-to-face interpreter services for at least one line of business. However, 30% reported that their delegated medical group, IPA, or individual provider exclusively arranges and pays for face-to-face interpreter services for some LEP members. Five percent of plans reported that they provide access information to commercial members who are responsible to arrange for their own face-to-face interpreter services.

TABLE 10 WHO ARRANGES AND PAYS FOR FACE-TO-FACE INTERPRETER SERVICES?
(Number of Plans By Line of Business)

	Commercial (n=12)	Medi-Cal (n=16)	Healthy Families (n=16)	Medicare (n=9)
Plan	4	10	12	4
Contractor*	4	6	4	4
Member	2	0	0	0
Not Reported	2	0	0	1

* A contractor may include a delegated medical group, an independent practice association, an individual provider, or in the case of a local initiative, a health plan partner.

Discouraging Members from Using Friends and Family as Face-to-Face Interpreters

As discussed, this issue is important to ensure precise and confidential communication between the provider and the patient. Many LEP members may not be aware that they have the right to request a face-to-face interpreter. Very few plans reported that the member is responsible to arrange for their own face-to-face interpreter. However, for those plans that report the member is responsible to arrange for their own face-to-face interpreter (see Table 10), one of two commercial plans reported that the member is expressly discouraged from using friends or family members to serve as interpreters.

How Members Are Informed about Accessing Face-to-Face Interpreter Services

Members are informed about accessing face-to-face interpreter services in different ways. Across all lines of business, 40% of health plans reported the use of posters to inform members of telephone interpreter services. Fifty percent of plans reported using member newsletters to inform members. Eighty percent of health plans reported that the member handbook/evidence of coverage contains information for members to obtain telephone interpreter services. Twenty-five percent of health plans reported reference to telephone interpreters on the plan website. Additionally, 55% of plans reported other methods to inform members about interpreter services.

HOW PLANS INFORM MEMBERS ABOUT FACE-TO-FACE INTERPRETER SERVICES **TABLE 11**
(Number of Plans By Line of Business)

	Commercial (n=12)	Medi-Cal (n=16)	Healthy Families (n=16)	Medicare (n=9)
Posters	4	8	7	3
Member Newsletter	2	10	10	1
Evidence of Coverage	3	16	15	4
Website	2	5	4	1
Other	5	7	8	4

Note: Health plans utilize multiple strategies to communicate with members. In this table, each cell represents the number of plans reporting a particular strategy for that line of business.

9. AMERICAN SIGN LANGUAGE INTERPRETERS

Across all lines of business, 17 out of 20 (85%) percent of health plans surveyed reported that they offer access to sign language interpreters for some, but not necessarily all, hearing impaired members at medical points of contact. Also, across all lines of business, all plans reported that sign language interpreter services are available at no cost for at least one line of business.

TABLE 12 SIGN LANGUAGE INTERPRETER SERVICES AT MEDICAL POINTS OF CONTACT (MPoCs)
(Number of Plans By Line of Business)

Line of Business (LOB)	Number of Plans Reporting LOB	Number of Plans Providing Sign Language Interpretation @ MPoCs	Percent
Commercial	12	8	67%
Medi-Cal	16	14	88%
Healthy Families	16	14	88%
Medicare	9	7	78%

TABLE 13 SIGN LANGUAGE INTERPRETER SERVICES PROVIDED AT NO COST TO MEMBER
(Number of Plans By Line of Business)

Line of Business (LOB)	Number of Plans Reporting LOB	Number of Plans Providing Sign Language Interpretation @ MPoCs	Percent
Commercial	12	9	75%
Medi-Cal	16	16	100%
Healthy Families	16	16	100%
Medicare	9	8	89%

Who Arranges and Pays for Sign Language Interpreter Services

Across all lines of business, 13 out of 20 (65%) of plans reported that they arrange and pay for sign language interpreter services for at least one line of business. However, 30% reported that their delegated medical group, IPA, or individual provider exclusively arranges and pays for sign language interpreter services for some, but not necessarily all, hearing impaired members. Five percent of plans reported a "not applicable" response.

TABLE 14 WHO ARRANGES AND PAYS FOR SIGN LANGUAGE INTERPRETER SERVICES?
(Number of Plans By Line of Business)

	Commercial (n=12)	Medi-Cal (n=16)	Healthy Families (n=16)	Medicare (n=9)
Plan	5	9	11	4
Contractor*	4	6	4	4
Member	1	0	0	0
Not Reported	2	0	0	0
Not Applicable	0	1	1	1

* A contractor may include a delegated medical group, an independent practice association, an individual provider, or in the case of a local initiative, a health plan partner.

Discouraging Members from Using Friends and Family as Sign Language Interpreters

As discussed, this issue is important to ensure precise and confidential communication between the provider and the patient. Very few plans reported that the member is responsible to arrange for their own sign language interpreter. However, for the one plan that reported the member is responsible to arrange for their own sign language interpreter (see Table 14), the plan also reported that the member is expressly discouraged from using friends or family members to serve as sign-language interpreters.

How Members Are Informed about Accessing Sign Language Interpreter Services

Members are informed about accessing sign language interpreter services in different ways. Across all lines of business, 45% of health plans reported the use of posters to inform members of sign language interpreter services. Fifty-five percent of plans reported using member newsletters to inform members. Eighty percent of health plans reported that the member handbook/ evidence of coverage contains information for members to obtain sign language interpreter services. Thirty-five percent of health plans reported reference to sign language interpreters on the plan website. Additionally, 50% of plans reported other methods to inform members about sign language interpreter services.

HOW PLANS INFORM MEMBERS ABOUT SIGN LANGUAGE INTERPRETER SERVICES **TABLE 15**
(Number of Plans By Line of Business)

	Commercial (n=12)	Medi-Cal (n=16)	Healthy Families (n=16)	Medicare (n=9)
Posters	5	8	7	4
Member Newsletter	2	9	10	2
Evidence of Coverage	4	15	14	4
Website	2	6	5	1
Other	5	6	7	4

Note: Health plans utilize multiple strategies to communicate with members. In this table, each cell represents the number of plans reporting a particular strategy for that line of business.

10. LIST OF BILINGUAL PROVIDERS

Availability of Provider Directory

Ninety-five percent of all plans reported that they have a provider directory that specifies non-English languages of their doctors, and 85% reported that they offer the provider directory in the plan's threshold languages for at least one line of business.

TABLE 16 LANGUAGE AVAILABILITY FOR PROVIDER DIRECTORIES
(Number of Plans By Line of Business)

	Commercial (n=12)	Medi-Cal (n=16)	Healthy Families (n=16)	Medicare (n=9)
Armenian	1	3	0	0
Chinese	2	6	4	0
Farsi	0	0	0	0
Hmong	0	2	0	0
Khmer	0	4	1	0
Korean	0	0	0	0
Russian	1	5	0	0
Spanish	9	15	15	6
Vietnamese	0	8	2	0

How Members Are Informed about Obtaining a Provider Directory

Members are informed about obtaining a provider directory in different ways. Across all lines of business, 20 health plans reported that the provider directory is available to members by request only. No health plan reported the use of posters to inform members of the provider directory. Twenty percent of plans reported using member newsletters to inform members. Fifty-five percent of health plans reported that the member handbook/evidence of coverage contains information for members to obtain a provider directory. Additionally, 55% of plans reported other methods to inform members about the provider directory.

TABLE 17 HOW PLANS INFORM MEMBERS ABOUT OBTAINING A PROVIDER DIRECTORY
(Number of Plans By Line of Business)

	Commercial (n=12)	Medi-Cal (n=16)	Healthy Families (n=16)	Medicare (n=9)
By Request Only	4	3	3	3
Member Newsletter	2	3	3	0
Evidence of Coverage	3	10	9	1
Other	5	8	8	2

Note: Health plans utilize multiple strategies to communicate with members. In this table, each cell represents the number of plans reporting a particular strategy for that line of business.

11. WRITTEN MATERIALS

Availability of Translated Written Materials

Translated written materials assist LEP members in accessing health plan services. Across all lines of business, 90% of plans reported that translated member materials are available to LEP members upon enrollment for at least one line of business. Twenty-five percent of plans reported that

translated member materials are available in specific languages upon member request only. Thirty-five percent of plans reported other methods.

HOW PLANS INFORM MEMBERS ABOUT OBTAINING TRANSLATED WRITTEN MATERIALS **TABLE 18**
(Number of Plans By Line of Business)

	Commercial (n=12)	Medi-Cal (n=16)	Healthy Families (n=16)	Medicare (n=9)
Upon Enrollment	9	15	15	6
By Request Only	5	1	2	2
Other	3	7	7	2

Note: Health plans utilize multiple strategies to communicate with members. In this table, each cell represents the number of plans reporting a particular strategy for that line of business.

LANGUAGE AVAILABILITY FOR EVIDENCE OF COVERAGE OR MEMBER HANDBOOK **TABLE 19**
(Number of Plans By Line of Business)

	Commercial (n=12)	Medi-Cal (n=16)	Healthy Families (n=16)	Medicare (n=9)
Armenian	1	5	0	0
Chinese	2	9	5	0
Farsi	0	1	0	0
Hmong	0	5	2	0
Khmer	0	5	0	0
Korean	0	1	2	0
Russian	1	8	0	0
Spanish	10	16	16	6
Vietnamese	0	11	3	0

LANGUAGE AVAILABILITY FOR MEMBER NEWSLETTERS **TABLE 20**
(Number of Plans By Line of Business)

	Commercial (n=12)	Medi-Cal (n=16)	Healthy Families (n=16)	Medicare (n=9)
Armenian	0	3	1	0
Chinese	1	6	5	0
Farsi	0	0	0	0
Hmong	0	1	1	0
Khmer	0	3	1	0
Korean	0	0	0	0
Russian	0	5	1	0
Spanish	6	15	15	2
Vietnamese	1	7	5	0

TABLE 21 LANGUAGE AVAILABILITY FOR MEMBER SATISFACTION SURVEYS
(Number of Plans By Line of Business)

	Commercial (n=12)	Medi-Cal (n=16)	Healthy Families (n=16)	Medicare (n=9)
Armenian	0	4	1	0
Chinese	3	7	6	1
Farsi	0	1	0	0
Hmong	0	2	0	0
Khmer	0	4	0	0
Korean	0	0	1	0
Russian	1	6	2	0
Spanish	6	15	13	5
Vietnamese	2	7	5	0

TABLE 22 LANGUAGE AVAILABILITY FOR GRIEVANCE/COMPLAINT PROCESS MATERIALS
(Number of Plans By Line of Business)

	Commercial (n=12)	Medi-Cal (n=16)	Healthy Families (n=16)	Medicare (n=9)
Armenian	1	4	0	0
Chinese	2	7	4	0
Farsi	0	1	0	0
Hmong	0	3	0	0
Khmer	0	4	0	0
Korean	0	1	1	0
Russian	0	6	0	0
Spanish	8	15	15	4
Vietnamese	1	8	3	0

TABLE 23 LANGUAGE AVAILABILITY FOR WELCOME MATERIALS
(Number of Plans By Line of Business)

	Commercial (n=12)	Medi-Cal (n=16)	Healthy Families (n=16)	Medicare (n=9)
Armenian	0	3	0	0
Chinese	3	7	4	1
Farsi	0	0	0	0
Hmong	0	2	0	0
Khmer	0	3	0	0
Korean	0	0	0	0
Russian	1	6	1	0
Spanish	7	14	14	5
Vietnamese	0	8	2	0

LANGUAGE AVAILABILITY FOR PREVENTIVE HEALTH CARE REMINDERS **TABLE 24**
(Number of Plans By Line of Business)

	Commercial (n=12)	Medi-Cal (n=16)	Healthy Families (n=16)	Medicare (n=9)
Armenian	0	1	0	0
Chinese	2	5	4	1
Farsi	0	0	0	0
Hmong	0	1	1	0
Khmer	0	1	0	0
Korean	0	0	0	0
Russian	0	3	2	0
Spanish	9	13	14	7
Vietnamese	1	6	5	0

12. GRIEVANCE/COMPLAINT PROCESS AND MONITORING

Language Barrier Complaint Monitoring

Across all lines of business, all plans reported that they monitor grievances/complaints specific to language barrier problems for all LEP members. In fact, 95% of plans reported that they monitor language barrier grievances/complaints via tracking of these specific complaints for at least one line of business. Also, all plans reported that they monitor general complaints for the occurrence of language barrier complaints.

Additionally, 50% of plans reported that they monitor language barrier complaints using member satisfaction surveys, while 30% reported that they monitor language barrier complaints using provider or staff surveys. Five percent of plans reported other methods.

Cultural Barrier Complaint Monitoring

Across all lines of business, all plans reported that they monitor grievances/complaints specific to cultural barrier problems for all LEP members. In fact, 95% of plans reported that they monitor cultural barrier grievances/complaints via tracking of these specific complaints for at least one line of business. Also, 90% of plans reported that they monitor general complaints for the occurrence of cultural barrier complaints.

Additionally, 40% of plans reported that they monitor cultural barrier complaints using member satisfaction surveys, while 25% reported that they monitor language barrier complaints using provider or staff surveys. Five percent of plans reported other methods.

How Members Are Informed about the Grievance Process in Threshold Languages

Across all lines of business, 15% of plans reported that they inform members how to file a grievance/complaint using posters; 50% reported using member newsletters; 95% reported having this information available in the evidence of coverage; and 60% reported using other methods.

TABLE 25 HOW PLANS INFORM MEMBERS ABOUT THE GRIEVANCE PROCESS IN THRESHOLD LANGUAGES
(Number of Plans By Line of Business)

	Commercial (n=12)	Medi-Cal (n=16)	Healthy Families (n=16)	Medicare (n=9)
Posters	1	3	2	0
Member Newsletter	4	9	9	2
Evidence of Coverage	9	16	16	8
Other	7	8	9	5

Note: Health plans utilize multiple strategies to communicate with members. In this table, each cell represents the number of plans reporting a particular strategy for that line of business.

13. DISCUSSIONS AND RECOMMENDATIONS

The voluntary participation of health plans in the survey process and the data findings show that many health plans are working toward and committed to providing linguistic services for their members. Nevertheless, there is room for continued improvement. Health plans should continue to strive to achieve appropriate linguistic services for all LEP members regardless of type of coverage. There is a business case to support this, and there are federal mandates for health plans that receive federal funds. But there is an even more compelling reason for health plans to do this. Simply, they are in the business of providing health care to members. By ensuring member access to appropriate linguistic services, health plans increase public accountability and may reduce inappropriate treatment, misdiagnosis, and unnecessary delay of needed medical care.

RECOMMENDATIONS

1. Health plans should provide the same linguistic access services to all members regardless of type of coverage. There is no clear reason why plans make a distinction in provision of linguistic services based on the member's type of coverage other than what they are required to do by contract. It is clear that quality of care and service quality depend greatly on the ability of the member to communicate with their doctor or their health plan representative. Health plans should not discriminate based on type of coverage.

2. Health plans should be responsible to assess member language needs and tailor services to those needs. Although health plans report that they collect and monitor member language information, these practices may not lead to a benefit for the member. Health plans should be responsible to know the preferred language of their members and to assure that the appropriate services are available at medical points of contact.

As noted, effective communication between a member and their treating physician or health plan representative is essential to render appropriate medical care. If this is not accomplished through a proficient bilingual provider or staff member, it may be achieved through an appropriate medical interpreter. All members should expect that their health plan will assist them in achieving effective communication.

3. Health plans should adopt standardized procedures for members to obtain interpreter services. The findings indicate variability in how members are informed about interpreter services as well as how telephone and face-to-face interpreter services are provided to members by health plans or their delegated contractors. This lack of consistent processes would appear to contribute to potential confusion for members. All health plans should adopt standardized procedures to inform members about the availability of interpreter services as well as how to obtain them.

4. Health plans should develop standardized processes for informing members about how to obtain translated written materials - especially how to obtain a bilingual provider directory. It is important for members to know how to access translated materials and where to obtain a provider directory. When asked in a focus group about cultural and linguistic services offered by health plans, Spanish speaking consumers in Los Angeles reported that one of the most important pieces of information that they would like from their health plan is a directory of bilingual providers with the specific language spoken by the doctor listed.

5. Health plans should uniformly evaluate the language proficiency of providers and bilingual staff. It is clear that while most plans evaluate bilingual staff using a standardized measure, the majority of plans rely on self-reports from their providers to assess language proficiency. Arguably, plans should take the same responsibility to assess both bilingual staff and providers. Additionally, if bilingual staff are providing interpreter services, ideally they should be evaluated for medical interpreter services, not simply linguistic proficiency.

Policy Implications

As discussed, at the present time, there is no explicit statutory requirement for cultural and linguistic services for health plans in California. Although there are contractual requirements stipulated by the Department of Health Services and Managed Risk Medical Insurance Board (MRMIB) in Medi-Cal and Healthy Families contracts as well as federal contract requirements for plans with Medicare contracts, there are currently no such requirements for plans with commercial lines of business or contracts.

The Department of Managed Health Care is the regulator for full service and specialty health plans in California. Its Division of Plan Surveys is responsible to assess Knox-Keene licensed health plans to ensure regulatory compliance with the Knox-Keene Act. The medical surveys conducted by this Division include a discussion of plan performance in the areas of health care accessibility, utilization management, quality improvement, grievance/appeal mechanisms, and overall plan performance in meeting enrollees' health care needs. These discussions sometimes incorporate matters related to LEP members, albeit in an indirect way. There is ongoing discussion among advocates and other stakeholders as to whether the current assessment of health plans is sufficient to fully address the needs of LEP members in California. The Department of Managed Health Care has recently adopted grievance process regulations that include specific requirements regarding the accessibility for LEP members. OPA will continue to work with the Cultural & Linguistic Services Work Group and the Department of Managed Health Care to improve and expand efforts in this area.

Conclusion

California's delegated model and the different types of coverage of members contribute to both the complexity of examining the provision of linguistic services of California health plans as well as presenting the information to consumers in a user-friendly format. Survey findings illustrate that some linguistic services are the responsibility of the health plan while others are delegated to health plan contractors. Additionally, the linguistic services offered may vary based on the member's type of coverage. The recommendations discussed here to standardize processes for informing members, regardless of type of coverage, begin to address the potential confusion that may unnecessarily limit access to entitled benefits.

Although descriptive information about linguistic services has some usefulness for consumers, future OPA efforts will focus on the development of relative performance quality measures for linguistic services. These measures will be incorporated in the annual HMO Quality Report Card. Development of quality measures to compare plans on the provision of linguistic services will enable HMO enrollees to compare plans in the same way they can with clinical and patient satisfaction measures. Additionally, the development of relative quality measures will contribute to the continued assessment of the provision of linguistic services. In this way, OPA can achieve its goal to improve and expand public accountability and access to health care for LEP consumers.

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